women iodide is useful and in the neuralgias of diabetics hypodermic injections of solution of potassium iodid often do good. These injections take the place of morphin. In albuminuria and nephritis morphin must be avoided.

GYNECOLOGY

UNDER THE CHARGE OF

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Large Doses of Radium in Cancer.—TURNER (*Lancet*, 1919, excvii, 1018) is of the belief that in treating cancer of the cervix with radium it is important to give at first a sufficiently large dose and he is accustomed to administer from 5 to 10 and even 15 thousand milligram hours and he states that he has never seen bad results follow such large doses. Suppose that the amount of radium employed in a particular case amounted to 100 mg., which is commonly the case, then a dose of 10,000 mg. hours would be administered by keeping it *in situ* for 100 hours. It might be suggested that it would be well to divide the exposure into two or more parts at intervals of a week or two, but Turner states that this will not answer and the whole dose should, if possible, be given at once. The patient should be kept in bed for a short period after exposure and should be douched. She may then return home but should report herself in about three months if all be going well, by which time it is possible that all the local evidences of the disease will have disappeared. Such dosage as Turner recommends is considerably in excess of the average dose of the American gynecologist for similar cases and it is very encouraging to note that such large doses can be given without causing extensive destruction of the surrounding tissues.

New Method of Uterine Suspension.—The permanent operative correction of a well marked uterine prolapse has always been one of the bugbears of gynecological surgery and therefore a new method of treatment which utilizes a strip of fascia lata, suggested by FREEMAN (*Surg., Gynec. and Obst.*, 1919, xxix, 511), may be of interest to those who have to treat such distressing conditions. Having obtained access to the abdominal cavity through a median suprapubic incision of sufficient size, the uterus is brought up into the opening and inspected. If the patient is still within the childbearing period, she must be sterilized, best by ligation of the tubes with silk, dividing them and perhaps folding the severed ends upon themselves. A strip of fascia lata, about six inches in length and three-fourths inch in width, is then obtained from the outer side of one of the thighs in the following manner: An incision of sufficient length is made through the skin and subcutaneous fat directly

down to but not through the glistening white fascia, and extending along the lateral aspect of the limb, midway between the trochanter and the knee. With a gauze covered finger the adipose tissue is pushed to either side so as to clear the field and the fascia divided in two parallel lines of the required length. The strip is then loosened and elevated by slipping the handle of a scalpel beneath it and sweeping the instrument from one end to the other. After dividing the attached ends with scissors the strip is removed and enveloped in moist gauze until required. The slit in the fascia lata from which the graft was taken may then be closed with a running suture of chromic gut, although this is not absolutely necessary because no harm will result if this is not done. Returning to the abdomen, the uterus is held firmly while a pair of small, sharp pointed, curved hemostatic forceps is plunged from one side to the other directly through the substance of the uterus close beneath the peritoneum covering the fundus, but not penetrating into the cavity. The forceps should be entered just internal to the attachment of one of the tubes and brought out at a corresponding point upon the opposite side, although if the organ is large it may be well to tunnel it somewhat more anteriorly in order to prevent undue pressure upon the bladder when the uterus is suspended from the tendons of the recti muscles. In order to facilitate the insertion of the forceps, it is occasionally desirable to nick the peritoneum with the point of a knife. When the forceps have been passed and are still in position, the fascia is doubled longitudinally upon itself, one end seized in the jaws of the instrument and the strip dragged through so that its center rests in the middle of the tunnel and its loose ends project from either side. Catgut stitches are then inserted so as to close the openings of the tunnel, thus preventing oozing and holding the fascia in place. The next step is to secure the ends of the fascia around the tendinous insertions of the recti muscles in order to bind the fundus of the uterus securely and closely to the anterior abdominal wall. This is accomplished first by stripping back the anterior sheaths of the muscles for a short distance above the pubes, so as to uncover the tendons, and plunging through these and the underlying peritoneum from without inward, a pair of pointed hemostatic forceps with which the ends of the fascial strip are seized and dragged into place, one on either side of the abdominal incision. After the peritoneum is closed, the ends of the fascial strip, which have been retained in forceps to prevent retraction, are pulled tight enough to hold the uterus firmly against the abdominal wall and are then crossed over the median line, best by tying them in a half-knot, and stitched securely to each other in several places by means of chromic gut so that they cannot slip. The wound is then closed in layers. Additional security against slipping may be obtained by catching the ends of the suspending fascia in the bight of a figure-of-eight silkworm-gut suture used in closing the abdominal incision. Fascia lata has a number of things in its favor: (1) It is easy to obtain in any desired quantity. (2) It is very strong and will not stretch to an appreciable extent, thus differing from the natural supporting ligaments of the uterus. (3) It does not become absorbed, like catgut, but incorporates itself within the tissues and permanently holds the uterus where it is placed.